

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: My Kind Heart	CHAPTER 100.1
Address: 98-034 Kulana Place, Pearl City, Hawaii 96782	Inspection Date: September 18, 2020 Initial

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. <u>FINDINGS</u> Substitute care giver (SCG) #3 - No examination by a physician. Submit a copy with the plan of correction (POC). SCG #4 - No examination by a physician. Submit a copy with the POC.	<p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;"><u>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</u></p> <p style="text-align: center;"><i>Yes</i></p> <p>I've attached here the copy of RE for SCG#3. I temporarily removed SCG#4 not to work for me until she will submit for vacant RE.</p>	<p style="text-align: center;">11/12/21</p> <p style="text-align: center;">11/12/21</p>

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<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. <u>FINDINGS</u> Primary care giver (PCG) - No tuberculosis (TB) clearance. Submit a copy with the POC. SCG #3 - No screen for symptoms consistent with pulmonary TB. Submit a copy with the POC. SCG #4 - No screen for symptoms consistent with pulmonary TB. Submit a copy with the POC.	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u> <u>Yes.</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Please see attached file for PCG. Please see attached file for SCG #3. For SCG #4, I removed her as my SCG until she will submit her recent TB test.</p>	<p style="text-align: center;">11/12/21</p> <p style="text-align: center;">11/12/21</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><u>FINDINGS</u> SCG #1 - No first aid certification. Submit a copy with the POC. SCG #2 - No first aid certification. Submit a copy with the POC.</p>	<p><u>DID YOU CORRECT THE DEFICIENCY?</u> <u>Yes!</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Please see attached file for SCG #1</p> <p>Please see attached file for SCG #2.</p> <p>I posted a spread sheet reminder on my bulletin board & check it every month.</p> <p>Alert all SCG ahead of time before it arrived five 3 months in advance</p>	<p>01/11/21 01/11/21</p> <p>1/11/21</p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation; <u>FINDINGS</u> SCG #1 - No cardiopulmonary resuscitation (CPR) certification. Submit a copy with the POC. SCG #2 - No CPR certification. Submit a copy with the POC.	<p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u> PART 1</p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>SCG #1 KORBELL W. HYDE Done with his CPR and got the certificate</p> <p>SCG #2 KATRINA LAM Done with her CPR last year</p> <p style="text-align: right;">4/26/19</p>	<p style="text-align: right;">5/15/20</p> <p style="text-align: right;">4/26/19 EXPIRES 4/26/21</p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-12 Emergency care of residents and disaster preparedness. (a)(3) The licensee shall maintain written procedures to follow in an emergency which shall include provisions for the following: Response to disasters which would include evacuation, emergency shelters, and food supply, and as directed by the Civil Defense. <u>FINDINGS</u> No disaster procedure. Submit a copy with the POC. ✓	<p style="text-align: center;">PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u> <i>Yes</i></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Please see attached file of Disaster Procedure.</i></p> <p><i>Every year i will review & check our updates</i></p>	<p><i>1/12/21</i></p> <p><i>1/12/21</i></p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-23 <u>Physical environment.</u> (h) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers. FINDINGS Missing light bulbs from the following light fixtures: Bedroom #2 - Two (2) of four (4) light bulbs missing. Bedroom #4 - One (1) of three (3) light bulbs missing. Bathroom - One (1) of three (3) light bulbs missing. Family room - One (1) of four (4) light bulbs missing.	<p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">PART 1</p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>yes. 1 Replaced all the light bulbs in Bedroom #2. 1've Replaced 2 light bulbs missing. Bedroom #4 - replaced 1 light bulb missing. Bathroom - replaced 1 light bulb missing. Family room - replaced 1 light bulb missing.</p>	<p style="text-align: right;">01/11/21</p>

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Licensee's/Administrator's Signature:

Print Name:

Date:

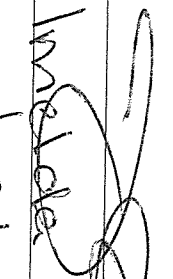

Pamela R. Hyde

10/05/2020

Licensee's/Administrator's Signature:

Print Name:

Date:


Pamela R. Hyde

01/12/2021